STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001106	A. BUILDING 00 B. WING	08/23/2011

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EVANSVILLE SURGERY CENTER ASSOCIATES LLC	4133 GATEWAY BLVD STE 100 NEWBURGH, IN47630

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S0000	This visit was for a State licensure survey. Facility Number: 002666 Dates: 8-22-11 through 8-23-11 Surveyors: Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor Deborah Franco, RN Public Health Nurse Surveyor QA: claughlin 09/09/11	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0230	410 IAC 15-2.4-1(e)(5) The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following: (5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility. Based on document review and interview, the governing body failed to ensure the Utilization Review Committee was comprised of physicians without a financial interest in the facility. Findings include: 1. Review of Utilization Review (UR) Committee membership, provided by #S1 on 8-23-11, indicated 6 of the 20 (P#1 - P#6) members of the Utilization Review Committee were owners of the ambulatory surgery center and listed as owners in the facility brochure given to patients. 2. Review of the UR Committee documents, provided by #S2 on 8-23-11 indicated the UR of the facility records is done by P#1 - P#6, owners in the facility. 3. An interview with #S2 was conducted 8-23-11 at 1030 hours and confirmed 6 of	S0230	**S230—**The Utlizaton Review Commitee fiuncton is fiacilitated through the Evansville Surgery Center (ESC) partcipaton in the Deaconess Hospital Surgery Department meetng . In the fiuture meetngs ofi the URC will consist ofi only non-investor physicians and will be refiected in the meetng minutes . The URC will meet in mid October, 2011 and those meetng minutes will be reviewed during the MEC at the next regularly scheduled meetng in January 2012 unless findings necessitate a meetng be called . The Perfiormance Improvement Coordinator is responsible fior fiacilitatng meetng ofi URC and reportng . The Facility Administrator and Managing Board have ultmate responsibility.	10/19/2011

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	the 20 members of the Utilization Review Committee have a financial interest in the ambulatory surgery center and 6 members of the UR Committee, who are owners, review the records of the facility.			
S0472	410 IAC 15-2.4-1(2)(h) (h) Environmental surfaces and equipment not requiring sterilization which have been contaminated by blood or other potentially infectious materials shall be cleaned then decontaminated in accordance with acceptable standards of practice and applicable state laws and rules, 410 IAC 1-4. Based on observation and staff interview, the facility failed to clean equipment and environmental surfaces contaminated with blood or other potentially infectious material in accordance with acceptable standards of practice and state rule 410 IAC 1-4 in one (1) of one (1) pathology rooms and failed to provide a policy addressing the cleaning of the pathology room in the surgical services department. Findings included: 1. On 8/23/2011 at 11:30 AM, in the presence of E #1, the following observations were made: a. In the surgery department, the room	S0472	**S472**—The Pathology room is not part of the Evansville Surgery Center and is maintained by Deaconess Laboratory as per contracted service agreement. The condition of the Pathology room was corrected same day as the survey. On September 20 th Deaconess Laboratory implemented a policy regarding cleaning of off-site facilities (See Attachment S 472 A). The ESC will add inspection of the pathology room as part of the quality oversight to see that the area is maintained according to "acceptable standards of practice and applicable state laws and rules" (See Attachment S 472 B). Staff education regarding reporting unacceptable conditions	09/20/2011

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	designated for use by pathologists to perform frozen sections contained a work area on the countertop including a cutting board, 1 ruler, 2 forceps, 1 scalpel, and 1 scissor which were soiled with a dried red substance on their working surfaces. b. The Vicon Acculab machine on the countertop was dusty and visibly soiled with splatters of a dried red substance. c. The drawer beneath the countertop labeled "Cutting Board" contained a piece of dried tissue measuring approximately 4cm by 4 cm. d. The telephone, counter, and cabinets were dusty and splattered with dried clear and red substances. 2. During interview with E #1 on 8/23/2011 beginning at 2:00 PM, E #1 verified the above and also indicated: a. the pathology room is for the exclusive use of pathologists. b. instruments used by the pathologists are not required to be sterilized prior to each use. b. a policy could not be produced which addesses the cleaning of the pathology room.		of Pathology Room will be presented and use of inspection tool to start by September 30th. Director of Operations will facilitate communications with the Pathology Department. The Performance Improvement Coordinator will report findings of inspection log to MEC and Managing Board on a quarterly basis as part of quality oversight of contracted services.	

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S0646	410 IAC 15-2.5-3(e)(3) All entries in the medical record must be as follows: (3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule. Based on medical record review and interview, the medical staff failed to ensure entries were authenticated by the responsible practitioner within 30 days in 6 of 30 closed medical records reviewed. Findings included: 1. On 8/23/2011, review of closed medical records indicated: A. N #4 was admitted on 05-02-2011. i. the operative report for N#4 was not authenticated. ii. N #4 was discharged on 05-02-2011. B. N #12 was admitted on 07/22/2011. i. the anesthesia pre-operative report was not authenticated. ii. N #12 was discharged on 07/22/2011. C. N #15 was admitted on 07/15/2011. i. the anesthesia pre-operative report was not authenticated. ii. N #15 was discharged on 07/15/2011. D. N #16 was admitted on 07/14/2011.	S0646	**S646— ESC's Medical Record Coordinator sends reminder notices to those physician's whose records are not authenticated within timeframe.** **Prior to suspension, the Medical Record**	10/10/2011

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	i. the anesthesia pre-operative report was not authenticated. ii. N #16 was discharged on 07/14/2011. E. N #19 was admitted on 07/20/2011. i. the operative report was not authenticated. ii. N #19 was discharged on 07/20/2011. F. N #21 was admitted on 07/06/2011. i. the history and physical were not authenticated. ii. N #21 was discharged on 07/07/2011. 2. During interview beginning at 12:30 PM on 08/23/2011, E #2 and E #5 verified the above.		**Coordinator post notices, sends faxed notices, and places phone calls to physicians who records are incomplete greater than 14 days after the date of surgery. Suspension of privileges occurs when records are not authenticated via letter from Medical Staff**	

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			President. Those delinquent physicians may not schedule surgery until all medical records are authenticated. Some records are electronically tagged for the physician's signature. Continuing education is provided for those doctors unfamiliar with	

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			the electronic signing of records. Completon ofi the medical record is contnually audited . Progress toward completeness ofi records will be reported to the MEC on October 10, 2011. The Medical Record Coordinator will be responsible fior the internal auditng process , the Perfiormance Improvement Coordinator and Facility Administrator will be responsible fior communicaton with the governing body. Ultmately , the Facility Administrator and the Medical Director will be responsible fior addressing physician compliance with completon ofi the Medical Record. Incremental improvements are expected untl compliance rate has reached 95%.	

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S0772	410 IAC 15-2.5-4(b)(3)(M) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (M) A requirement that a medical history and physical examination be performed as follows: (i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed. (ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff. (iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy. Based on medical record review and interview, the medical staff failed to ensure that a history and physical examination was performed in 1 of 30 closed medical records reviewed. Findings included: 1. The medical record of N #20, admitted	S0772	**S772** P&P # 3001, History & Physical (Attachment S772 A) was revised on 6/28/11 to include verbiage regarding updates to H&Ps performed greater than 24 hours prior to procedure. New form, Physician Progress Notes (Attachment S 772 B) was developed on 6/28/11 which will be included in the above mentioned policy. Policy was reviewed and approved by the	09/30/2011

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	and discharged 7/21/2011, lacked a pre-operative history and physical. 2. During interview beginning at 12:30 PM on 08/23/2011, E #2 and E #5 verified the above.		Medical Executive Committee on 7/11/11. Education to the physicians occurred at the Medical Staff Meeting on 8/1/11. A letter was also sent to all physicians on the medical staff dated 8/1/11. Final policy approval by the Managing Board will be on 9/28/11. Education to clinical staff will be completed by 9/30/11. Monthly medical record review of 30 records (Attachment S772 C) will be completed by Medical Records Coordinator. Auditing will continue until 95% compliance is demonstrated. Thereafter quarterly monitoring performed.	
S0900	410 IAC 15-2.5-5(a) (a) All patient care services must meet the needs of the patient, within the scope of the service offered, in accordance with acceptable standards of practice. Patient care services must be under the direction of a qualified person or persons. Patient care services must require the following: Based on medical record review and interview, the facility failed to follow physician's orders in the administration of blood to two (2) of three (3) patients receiving blood transfusions. Findings included: 1. Review of the medical record for N	S0900	**S900**—Physician notified of need to clarify orders for autologous blood administration order to be worded to fit his practice on September 19th. He had erroneously indicated administering packed cells when in actuality he wanted patient to receive back the autologous blood donated prior to date of procedure (which is what	09/19/2011

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	#19 indicated: a. The surgeon ordered type and crossmatch for "2 units autoblood stat on admission". b. Post-operative orders included "give 2 units packed cells". c. One (1) unit of autologous whole blood was transfused. 2. Review of the medical record of N #21 indicated: a. The surgeon ordered type and crossmatch for "autologus blood 2 units". b. Post-operative orders included "give 2 units packed cells". c. One (1) unit of autologous whole blood was transfused. 3. During interview with E #1 beginning at 2:00 PM on 08/23/2011, E #1 verified the above.		happened). ESC staff to be provided with education regarding medico-legal requirements of the patient record to demonstrate that physicians' orders are followed as written, unless the order has been amended or documentation provides explanation as appropriate. Education will be provided by September 30 th , 2011. Monitoring of all blood administration records is ongoing as per quality monitoring. An additional line item for blood administration monitoring will include accuracy of order completion. Any variances will be addressed with staff involved in the care. See Attachment 900 A for example of monitoring to begin October 1, 2011.	

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